AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

Federal Register

Wednesday,
May 26, 2004

Part V

Department of Labor

Employee Benefits Security Administration

29 CFR Part 2590

Health Care Continuation Coverage; Final Rule

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210–AA60

Health Care Continuation Coverage

AGENCY: Employee Benefits Security Administration, Labor.

ACTION: Final rules.

SUMMARY: This document contains final rules implementing the notice requirements of the health care continuation coverage (COBRA) provisions of part 6 of title I of the Employee Retirement Income Security Act of 1974 (ERISA or the Act). The continuation coverage provisions generally require group health plans to provide participants and beneficiaries who under certain circumstances would lose coverage (qualified beneficiaries) the opportunity to elect to continue coverage under the plan at group rates for a limited period of time.

The final rules set minimum standards for the timing and content of the notices required under the continuation coverage provisions and establish standards for administering the notice process. These rules affect administrators of group health plans, participants and beneficiaries (including qualified beneficiaries) of group health plans, and the sponsors and fiduciaries of such plans. These rules also provide model notices for use by administrators of single-employer group health plans to satisfy their obligation to provide general notices and election notices.

DATES: Effective date: These regulations are effective July 26, 2004.

Applicability date: These regulations apply to notice obligations arising under the COBRA provisions of part 6 of title I of ERISA on or after the first day of the first plan year beginning on or after the date that is six months after May 26, 2004.

FOR FURTHER INFORMATION CONTACT: Lisa M. Alexander or Suzanne M. Adelman, Office of Regulations and Interpretations, Employee Benefits Security Administration, (202) 693–8500. This is not a toll-free number.

SUPPLEMENTARY INFORMATION:

A. Background

The continuation coverage provisions, sections 601 through 608 of title I of ERISA, were enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which also promulgated parallel provisions that became part of the Internal Revenue Code (Code) and the Public Health ServiceAct (PHSA). [1] *See* Code section 4980B; PHSA, 42 U.S.C. 300bb–1 *et seq.* These provisions are commonly referred to as the COBRA provisions, and the continuation coverage that they mandate is commonly referred to as COBRA coverage. The COBRA provisions of title I of ERISA generally require that ''any group health plan'' [2] offer ''qualified beneficiaries'' the opportunity to elect ''continuation coverage'' following certain events that would otherwise result in the loss of coverage (''qualifying events'').[3] Continuation coverage is a temporary extension of the qualified beneficiary's previous group health coverage. The right to elect continuation coverage allows individuals to maintain group health coverage under adverse circumstances and to bridge gaps in health coverage that otherwise could limit their access to health care.

COBRA, as enacted, provides that the Secretary of Labor (the Secretary) has the authority under section 608 of ERISA to carry out the provisions of part 6 of title I of ERISA. The Conference Report that accompanied COBRA divided interpretive authority over the COBRA provisions between the Secretary and the Secretary of the Treasury (the Treasury) by providing that the Secretary has the authority to issue regulations implementing the notice and disclosure requirements of COBRA, while the Treasury is authorized to issue regulations defining the required continuation coverage.[4] Under its authority to interpret the COBRA provisions, the Treasury has issued final regulations that provide rules for determining which plans are subject to the COBRA provisions, who is or can become a qualified beneficiary, which events constitute qualifying events, what COBRA obligations exist in the case of mergers and acquisitions, and the nature of the continuation coverage that must be offered. See Treas. Reg. §§ 54.4980B–1 through 54.4980B–10.

On May 28, 2003, the Department of Labor (the Department) published in the **Federal Register** (68 FR 31832) proposed regulations governing the timing, content, and administration of the notice obligations arising under sections 601 through 608 of ERISA.[5] In response to the proposed COBRA notice regulations, the Department received 26 public comments from an array of interested parties, including organizations representing employers, group health plans, plan administrators, persons specializing in COBRA administration, and participants and beneficiaries.

The Department has made a number of changes to the regulations and model notices in response to the public comments received on the proposals. The following provides an overview of the final rules, public comments, and changes from the proposed regulations. These final rules implementing the notice requirements of the COBRA provisions of part 6 of title I of ERISA also apply for purposes of the COBRA provisions of section 4980B of the Code.[6]

[1] The Code and PHSA COBRA provisions, although very similar in other ways, are not identical to the COBRA provisions in title I of ERISA in their scope of application. The PHSA provisions apply only to State and local governmental plans, and the Code provisions grant COBRA rights to individuals who would not be considered participants or beneficiaries under ERISA. *See* PHSA, 42 U.S.C. 300bb–8; Code section 5000(b)(1).

[2] A group health plan is not subject to the COBRA provisions for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year. *See* ERISA section 601(b).

[3] Each of the quoted terms is specifically defined in the COBRA provisions. In particular, the term ''group health plan'' is defined in section 607(1) of the Act to mean an employee welfare benefit plan as defined in section 3(1) of the Act that provides medical care (as defined in section 213(d) of the Code) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise. The Department notes that employee welfare benefit plans under ERISA include, *inter alia*, plans sponsored by unions for their members as well as plans sponsored by employers for their employees. Such union-sponsored plans would not involve employers in any sponsorship capacity, nor would they necessarily cover individuals all of whom are employees. Although the proposed regulations use the terms ''employer'' and ''employee,'' as do the COBRA provisions, in assigning duties, they are intended to apply to all group health plans, as defined in section 607(1) of the Act, subject to COBRA.

[4] H.R. Conf. Rep. No. 99–453 at 562–63 (1985). The Conference Report further indicated that the Secretary of Health and Human Services, who is to issue regulations implementing the continuation coverage requirements for State and local governments, must conform the actual requirements of those regulations to the regulations issued by the Secretary and the Treasury. *Id.* at 563.

[5] Prior to the development of proposed rules, the Department published a Request for Information (RFI) to assess public views on the advisability of developing regulations on the COBRA notice provisions. *See* 62 FR 49894 (Sept. 23, 1997). The Department received 15 comments, all of which were taken into account in developing the proposed rules.

[6] As noted in footnote 1, above, certain COBRA provisions (such as the definitions of group health plan, employee and employer) are not identical in the Code and title I of ERISA. The Treasury has reviewed these rules and concurs that, in those cases in which the statutory language is not identical, §§ 2590.606–1 through 2590.606–4 would nonetheless apply to the COBRA provisions of § 4980B of the Code, except to the extent that such regulations are inconsistent with the statutory language of the Code.

B. Overview of Final Regulations

The final COBRA notice rules, like the proposals, consist of four separate regulations. Section 2590.606–1 covers the general notice requirement. In an appendix to § 2590.606–1, a model general notice is provided to facilitate compliance with the general notice requirements. Section 2590.606–2 creates rules for employer-provided notices of the occurrence of a qualifying event. Section 2590.606–3 addresses the responsibilities of qualified beneficiaries to provide notice of a qualifying event or a disability. Section 2590.606–4 deals with the election notice and other notices that plan administrators must provide. In an appendix to § 2590.606–4, a model election notice is provided to facilitate compliance with the election notice requirements.

The model notices provided in the appendices to §§ 2590.606–1 and 2590.606–4 are intended to be used by single-employer plans. Other types of plans, such as multiemployer plans and plans sponsored by unions for their members, would have to modify the model notices to reflect the special rules or practices that apply in the case of such plans.[7] The Department further notes that the use of the model notices is not required. The model notices included with these regulations are provided solely for the purpose of facilitating compliance with the applicable notice requirements. The furnishing of appropriately and accurately completed model notices, however, will be considered by the Department to constitute compliance with the requirements of the applicable notice regulation.

Section 2590.606–1 General Notice

Section 606(a)(1) of ERISA requires group health plans to provide written notice of COBRA rights to each covered employee and spouse (if any) ''at the time of commencement of coverage'' under the plan. Section 2590.606–1 establishes the time frames within which this general notice must be provided and describes the specific information that the general notice must contain.

The final regulation retains the same general structure of the proposal. As discussed below, however, some changes to both the regulation and the accompanying model general notice have been made in response to public comments.

Paragraph (b) of the final regulation addresses the timing requirements applicable to the general notice requirement of section 606(a)(1) of the Act. Similar to the proposal, paragraph (b) establishes a 90-day period for furnishing the general notice. Generally, the notice must be furnished to each covered employee and to the employee's spouse (if covered under the plan) not later than the earlier of: (1) either 90 days from the date on which the covered employee or spouse first becomes covered under the plan or, if later, the date on which the plan first becomes subject to the continuation coverage requirements; or (2) the date on which the administrator is required to furnish an election notice to the employee or to his or her spouse or dependent.

While a few commenters expressed concern about the timing of the general notice, the majority of commenters supported the provision as better reflecting current practice and fostering efficiency through its possible combination with the summary plan description (SPD). The Department continues to believe that the timing requirements of the regulation protect covered employees and their spouses during the first 90 days of coverage by ensuring that they timely receive all the information they need to understand their rights. For this reason, the Department has retained the timing provisions as proposed. In response to several comments requesting clarification that the date for the furnishing of the general notice under the regulation is the ''commencement of coverage'' date for purposes of section 606(a)(1) of the Act, the Department has added a new paragraph (§ 2590.606–1(b)(2)), providing that a notice furnished in accordance with the timing requirement of the regulation is deemed to be provided at the time of commencement of coverage under the plan.

A number of commenters questioned the need to furnish a general notice in addition to an election notice when the election notice must be given to an individual within the initial 90-day period of coverage. Having reviewed the information required to be contained in the general notice described in § 2590.606–1(c), and the election notice described in § 2590.606–4(b)(4), the Department believes that, given the comprehensive nature of the information in the election notice and its importance to a qualified beneficiary, the furnishing of a general notice simultaneously with an election notice during the initial 90-day period would be duplicative, if not confusing or distracting. To address this issue, a new paragraph (§ 2590.606–1(b)(3)) has been added to the final regulation providing that, where an individual is required to be furnished an election notice within the 90-day period for furnishing general notices, the plan administrator may satisfy its general notice obligation by furnishing an election notice in accordance with the final regulation (§ 2590.606–4(b)).

Paragraph (c) of the regulation sets forth the required minimum content of a general notice. These content requirements cover basic information regarding COBRA and the rights and responsibilities of qualified beneficiaries that a participant or beneficiary would need to know before the occurrence of a qualifying event in order to be able to protect his or her COBRA rights.

Several commenters argued that the proposed regulation and model notice should be modified to eliminate or reduce plan-specific information. These commenters generally argued that the use of ''generic'' (non-plan specific) general notices could result in cost-savings since the same notice could be used without customization by COBRA administrators for multiple plans. While the Department appreciates the arguments in favor of a ''generic'' notice, the Department believes that covered employees and spouses need to know the name of the plan and a plan contact for further continuation coverage and plan information. The Department notes that Technical Release 86–2 (June 26, 1986), which provided a model general notice for use shortly after COBRA was enacted, required inclusion of plan-specific information for the same reasons. The Department, therefore, has retained these requirements in the regulation. However, in an effort to minimize the difficulty of customizing the general notice, the Department has modified the model general notice to allow placement of plan-specific identification information at the end of the notice. The Department also has modified the model general notice to eliminate identification of both the plan administrator and the COBRA administrator. As modified, the model general notice requires only the name, address, and phone number of a party or parties who will provide information about the plan and COBRA upon request.

A number of commenters argued that the general notice should not be required to address the responsibilities of qualified beneficiaries to provide notice of second qualifying events, noting that such information is more appropriate for the SPD and election notices. The Department agrees with the commenters that the general notice

[7] The model election notice is not designed to be used when bankruptcy is the qualifying event.

should be as informative as possible without being unnecessarily complex. For this reason, the Department has modified paragraph (c)(4) to eliminate the proposed requirement that the notice describe how qualified beneficiaries who are receiving continuation coverage must provide notice of a second qualifying event. In addition to being included in plan SPDs, this information is included as part of the election notice required under § 2590.606–4 and, therefore, will be furnished when it will be more relevant to the qualified beneficiary.

Commenters also argued that, because different qualifying events under a single plan may produce different COBRA coverage start dates (since the plan may choose to begin COBRA coverage on either the date of the qualifying event or the date of loss of coverage), requiring that specific information to be described in the general notice makes the notice unnecessarily complicated, particularly since this information will be available in SPDs. The commenters assumed the regulation required such detail because the proposed model general notice provided for inclusion of this information. The Department agrees with the commenters that such information should not be required as part of the general notice if it will make the notice unnecessarily complicated. While no changes are required to the regulation, to avoid any confusion, the Department has modified the model general notice to eliminate references to COBRA coverage beginning dates. The Department notes, however, that nothing in the regulation or the model general notice precludes a plan administrator from including such information in a plan's general notice.

A few commenters expressed concern that the proposal required the general notice to include a statement that more complete information about continuation coverage and other rights under the plan is available from the plan administrator and the plan's SPD. Because covered employees and spouses may need additional information about their rights under their plan, the Department believes that they should be reminded that there are sources for that information, namely the plan administrator and the plan's SPD. Therefore, this provision is retained in the final regulation.

Paragraph (d) permits delivery of a single notice addressed to a covered employee and the covered employee's spouse at their joint residence, provided the plan's latest information indicates that both reside at that address. A single notice would not be permitted, however, if a spouse's coverage under the plan begins at a different time from the covered employee's coverage, unless the spouse's coverage begins before the date on which the notice must be provided to the covered employee, and a single notice is then timely sent to their joint address. In response to one commenter's request, paragraph (d) has been revised to clarify that there is no requirement to furnish a general notice to dependent children, even if the general notice requirement is triggered early by the occurrence of a qualifying event involving such an individual.

As indicated in the preamble to the proposal, in-hand furnishing of the general notice at the workplace to a covered employee is deemed to be adequate delivery to the employee, although such delivery to the employee would not constitute delivery to the spouse. Except for minor editorial changes intended to make the provision more clear, this paragraph is being retained as proposed.

Paragraph (e) of the final regulation permits plans to satisfy the general notice requirement by including the information described in paragraphs (c)(1), (2), (3), (4), and (5) in the SPD of the plan and providing the SPD at a time that complies with the timing requirements for the general notice. Some commenters argued that, given the importance of the information it contains, the general notice should be required to be furnished as a stand-alone notice, as well as being included in the SPD. The Department continues to believe that many, and perhaps most, plans would prefer to take advantage of the reduced cost and added efficiency of providing a single disclosure document that satisfies both the general notice requirement and the SPD requirement. Moreover, the Department believes that participants and beneficiaries are more likely to retain and have ready access to their SPD than a general notice furnished separate and apart from their SPD. The Department, therefore, has retained this provision without change. The Department emphasizes, however, that retention of this provision is not intended in any way to limit a plan's flexibility to provide other information in other forms to its employees and the spouses of its employees.

As noted in the proposal, if a plan chooses to satisfy its SPD and general notice obligations by furnishing a single document, the plan must ensure that the document satisfies both the general notice content requirements and the SPD content requirements.[8]

Paragraph (f) provides that delivery of the general notice must be made in accordance with the standards of 29 CFR 2520.104b-1, including the standards for use of electronic media. There were no comments suggesting changes to this provision. Accordingly, the provision is being adopted without change. A discussion of general issues relating to the furnishing of notices is contained in section C, entitled ''Miscellaneous.''

The model general notice appended to § 2590.606–1 has been revised to reflect the changes discussed above. The Department also has made a number of editorial changes in response to suggestions and recommendations to improve the clarity of the model general notice.

Section 2590.606–2 Employer's Notice of Qualifying Event

Section 606(a)(2) of ERISA requires an employer to provide notice to the plan administrator of a qualifying event that is either the employee's termination of employment or reduction in hours of employment, the employee's death, the employee's becoming entitled to Medicare, or the commencement of a proceeding in bankruptcy with respect to the employer. Regulation § 2590.606–2 addresses this notice obligation of employers.

Paragraph (b) of the regulation provides that an employer shall notify the plan administrator of a qualifying event no later than 30 days after the date of the qualifying event. However, paragraph (b) further provides that, for any plan under which continuation coverage begins, pursuant to section 607(5) of the Act, with the date of loss of coverage, the 30-day period for providing the notice of qualifying event must also begin with the date of loss of coverage, rather than the date of the qualifying event. Paragraphs (b) and (d) also recognize that multiemployer plans may have different notice periods, as permitted under sections 606(a)(2) and 606(b).

Paragraph (c) of the regulation requires that an employer provide the plan administrator sufficient information to enable the administrator to determine the identity of the plan, the covered employee, the qualifying event, and the date of the qualifying event.

The comments received by the Department on this regulation supported the approach taken in the proposal. The Department, therefore, is

[8] The SPD content regulation, § 2520.102–3, specifies other information, in addition to description of COBRA rights, that must be included in an SPD for a group health plan. See, *e.g.*, § 2520.102–3(j), (l), (s).

adopting this section without modification.

Section 2590.606–3 Qualified Beneficiaries' Notices

Under section 606(a)(3) of the Act, each covered employee or qualified beneficiary is responsible for notifying the plan administrator of a qualifying event that is either the divorce or legal separation of the employee from his or her spouse or a child's becoming no longer eligible to be covered as a dependent under the plan. Regulation § 2590.606–3 provides guidance with respect to this notice obligation and other notice obligations of qualified beneficiaries, such as the notice of disability or second qualifying event. Except as noted below, the final regulation follows the framework of the proposal.

Paragraph (a) describes the notices that covered employees and qualified beneficiaries may be required to provide to the administrator, which include notices of the occurrence of a qualifying event that is a divorce, legal separation, or a child's ceasing to be a dependent under the plan; the occurrence of a second qualifying event; a determination of disability by the Social Security Administration; and a determination by the Social Security Administration that a qualified beneficiary is no longer disabled.

Paragraph (b) of the final regulation, like the proposal, requires plans to establish reasonable procedures for the furnishing of these notices and sets general standards for what will be considered reasonable.[9] Under this provision, a plan's procedures generally will be considered reasonable if they are described in the plan's SPD, specify who is designated to receive notices, and specify the means qualified beneficiaries must use for giving notice and the required content of the notice. Paragraph (b) further provides that, if a plan does not have reasonable procedures for qualified beneficiaries' notices, notice will be deemed to have been provided when a written or oral communication identifying a specific event is communicated in a manner reasonably calculated to bring the information to parties that would customarily be considered to be responsible for the plan. The proposed regulation specified that, in the case of a single-employer plan that failed to adopt reasonable procedures, notice would be deemed provided if communicated either to the person or organizational unit that has customarily handled employee benefit matters of the employer or to any officer of the employer.

While some commenters expressed concern that requiring plans to adopt qualified beneficiary notice procedures may force them into creating formal, inflexible procedures that will harm participants, most commenters recognized and supported the importance of establishing notice processes that are clearly communicated to the plan's participants and beneficiaries. With regard to plans that fail to adopt reasonable procedures, some commenters suggested that notice should also be deemed to have been provided if given to the managers and supervisors of the employee. Other commenters argued that recognizing oral notifications and notifications given to the officers of an employer would cause confusion and uncertainty as to when and if notice was provided. In response to these comments, the Department has decided to retain the default standards recognizing oral notifications, where a plan fails to adopt reasonable notification procedures. To restrict the default notice standards to recognize only written communications would allow plans that fail to adopt express notice procedures to rely on a de facto standard requiring written notice, which in the Department's view would be unfair to participants and beneficiaries. However, the Department recognizes that the breadth of the approach of the proposed regulation in this regard may have the potential for uncertainty and confusion. Since it is reasonable to expect an employee or qualified beneficiary, even in the absence of reasonable plan procedures, to give notice of an event to a party that customarily handles employee benefit matters, the Department has eliminated the reference, at § 2590.606–3(b)(4)(i), to ''any officer of the employer.''

Like the proposal, paragraph (b)(3) of § 2590.606–3 provides that plans may require qualified beneficiaries to provide specific information via a specific form, if the form is easily available to qualified beneficiaries without cost. One commenter objected to allowing plans to require use of a specific form for notice of qualifying event. The Department believes that employees and qualified beneficiaries may, in fact, benefit from a plan's use of specific forms, which would remove uncertainty about how to comply with the plan's requirements. The Department, therefore, has retained this provision in the final regulation without change.

Paragraph (c) provides the time limits that may apply to qualified beneficiaries' notices. These limits are minimums that may be imposed by a plan. There is nothing in the regulation that prevents plans from providing longer periods for furnishing these notices. In general, a plan must allow an employee or qualified beneficiary at least 60 days to provide notice of a qualifying event that is divorce, legal separation, a child's ceasing to be a dependent under the plan, or a second qualifying event. As proposed, the starting date for the minimum 60-day period was based, in part, on what the plan provided for the start of COBRA coverage pursuant to section 607(5) of the Act. At the suggestion of a commenter and for purposes of simplicity, the Department has restructured paragraph (c)(1) of § 2590.606–3 to conform with Treasury regulations by providing that the 60-day period begins to run from the latest of: (1) The date of the qualifying event; (2) the date on which there is a loss of coverage; or (3) the date on which the qualified beneficiary is informed, through the plan's SPD or the general COBRA notice, of his or her obligation to provide notice and the procedures for providing such notice. See Treas. Reg. § 54.4980B–6, Q&A–2.

One commenter questioned why the regulation requires the furnishing of an SPD or general COBRA notice before the 60-day period for notices of qualifying event may begin to run against a qualified beneficiary. Inasmuch as a qualified beneficiary might be denied continuation coverage because he or she failed to furnish timely notice of a qualifying event, the Department believes that disclosing the notice obligations and the procedures for providing such notice is critical to the exercise of statutory rights. The framework of the final regulation, like the proposal, is intended to ensure that qualified beneficiaries will not be adversely affected in efforts to exercise their COBRA rights by a plan's failure to provide adequate disclosure.

Several commenters raised questions concerning the time limits, at § 2590.606–3 (c)(2) of the proposed rule, for notices of disability determinations.[10] Specifically, the

[9] ERISA does not mandate that qualified beneficiaries provide notices of qualifying event or disability. A qualified beneficiary may not wish to elect or extend continuation coverage and may therefore decide to forgo providing the notice of qualifying event without violating the COBRA provisions.

[10] The COBRA provisions require group health plans to provide certain qualified beneficiaries an 11-month disability extension of an 18-month period of COBRA coverage (resulting in a total of 29 months of COBRA coverage), provided the qualified beneficiary (or any other qualified beneficiary who is a member of his or her family)

Continued

commenters suggested that the proposal was ambiguous with respect to individuals who receive a disability determination from the Social Security Administration (SSA) at some time prior to the occurrence of a qualifying event. Since the proposed regulation would permit plans to require qualified beneficiaries to provide a disability notice within 60 days of the later of (1) the date of the SSA disability determination, or (2) the date on which the qualified beneficiary is notified of the obligation to provide the disability notice, the commenters requested that the Department clarify whether and how these rules would apply to individuals who received an SSA disability determination before receiving notice of the obligation to provide the disability notice. The commenters noted that the Treasury regulations create a rule for individuals who have been determined by SSA to be disabled prior to the occurrence of a qualifying event under which their disability is considered to continue to exist as of the qualifying event, provided SSA has not issued a subsequent determination that they are no longer disabled. Under the Treasury regulations, therefore, qualified beneficiaries who have a prior SSA disability determination are considered to meet the statutory requirement of being disabled ''within the first 60 days'' of COBRA coverage. *See* Treas. Reg. § 54.4980B–7, Q&A–5(c).

The Department agrees with the commenters that there is a need for further clarification in this area. Following a review of section 606(a)(3) of the Act, the legislative changes to the COBRA provisions since 1986, and the Treasury regulations, the Department has concluded that, for purposes of section 606(a)(3) of the Act, an SSA disability determination, once issued, should be considered to remain in continuing effect until the SSA makes a contrary determination.[11] For this reason, the Department believes that section 606(a)(3) is best interpreted to permit plans to require qualified beneficiaries to provide a disability notice within 60 days after the latest of: (1) The date of the SSA disability determination; (2) the date on which the qualifying event occurs; (3) the date on which the qualified beneficiary loses coverage; or (4) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice. The final regulation reflects this interpretation in § 2590.606–3(c)(2). Under this interpretation, an individual who previously received an SSA disability determination and has not received a subsequent SSA determination that he or she is no longer disabled would have at least 60 days after the occurrence of a qualifying event to provide the plan with a disability notice in order to be entitled to the disability extension.[12] There is nothing that precludes plans from allowing a longer period for providing this notice. For example, a plan may find it administratively more convenient to permit individuals who receive an SSA determination prior to a qualifying event to provide the notice of disability within the same time period within which the election notice is required to be provided.

Paragraph (d) of § 2590.606–3, like the proposal, provides that a plan may not reject an incomplete notice as untimely if the notice is provided within the plan's time limits and contains enough information to enable the plan administrator to identify the plan, the covered employee and qualified beneficiar(ies), the qualifying event or disability determination, and the date on which such event or determination occurred. However, if a timely notice fails to supply all of the information required under the plan's procedures, the plan administrator can require qualified beneficiaries to supply the missing information. Several commenters asked for a clarification as to whether a plan could reject a deficient notice if, following a request to provide the information required by the plan's procedures, a covered employee or qualified beneficiary fails to provide the requested information. It is the view of the Department that there is nothing in the final regulation that would preclude a plan, following a request for more complete information, from rejecting a notice when an employee or qualified beneficiary fails to provide the requested information within some reasonable period of time. The Department believes that both the plan and the plan's participants and beneficiaries would benefit from a procedure that specifically defines when and under what circumstances, following a request for more complete information, a notice will be rejected due to a failure to provide the information a plan requires.[13]

In view of the comments, paragraph (d) of the proposal is adopted without modification. Inasmuch as no comments were submitted on paragraphs (e) through (g) of the proposal, those paragraphs are also adopted as proposed.

Section 2590.606–4 Plan Administrator's Notice Obligations

Section 606(a)(4) of ERISA requires a plan administrator to notify each qualified beneficiary who is entitled to elect continuation coverage of his or her COBRA rights. Section 606(c) requires a plan administrator to provide such notice within 14 days after the plan administrator is notified of a qualifying event. Regulation § 2590.606–4 provides guidance on the requirements of sections 606(a)(4) and 606(c). In general, the regulation describes timing and content requirements for election notices, requires administrators to notify individuals under certain circumstances if continuation coverage is determined not to be available, and requires plan administrators to provide notice when continuation coverage terminates before the end of the maximum period for such coverage.

Paragraph (a) of the final regulation describes the obligation of the administrator of a group health plan to provide qualified beneficiaries with notice of their right to elect continuation coverage under the plan.

Paragraph (b) of the final regulation addresses the specific timing and content requirements for the election notice.[14] With regard to timing,

is both determined by SSA to be disabled during the first 60 days of COBRA coverage and also provides notice to the plan of SSA's disability determination within 60 days after the date of the determination. The notice must be provided before the end of the first 18 months of continuation coverage. *See* ERISA sections 602(2)(A); 606(a)(3).

[11] Congress recognized the continuing effect of an SSA disability determination by including in the COBRA provisions both a provision requiring a qualified beneficiary who provides a disability notice to provide the plan with a subsequent notice if the SSA determines him or her to be no longer disabled and a provision permitting plans to terminate the 11-month disability extension one month after the SSA makes a determination that the qualified beneficiary is no longer disabled. *See* ERISA sections 602(2)(E); 606(a)(3).

[12] The general notice requirement would also have to have been fulfilled with respect to that individual. Since the general notice is required to be furnished only to the covered employee and spouse (if also covered), the Department will consider furnishing the general notice to either of those two individuals adequate notice with respect to a disabled child of the covered employee for this purpose.

[13] The plan's procedures must be reasonable in all respects, including the rules for what information is required, how much time an individual is given to provide the required information, and the bases for accepting or rejecting a notice.

[14] The regulation requires an administrator to provide an election notice only when it has been determined that a qualified beneficiary is entitled to elect continuation coverage. In this regard, the Department notes that it is the administrator's responsibility to determine whether individuals who are named in a notice of qualifying event are entitled to continuation coverage and that disputes may arise over the correctness of the administrator's determinations. The Department further notes that determinations regarding eligibility for COBRA continuation coverage, like determinations involving eligibility for coverage under a group

paragraph (b)(1) of the final regulation generally provides that the administrator shall furnish an election notice to qualified beneficiaries within 14 days after the receipt of notice of a qualifying event.

Paragraph (b)(2) provides a special timing rule in connection with qualifying events for which the employer must notify the plan, where the employer is also the administrator of the plan. Under the special rule, an election notice must be furnished not later than 44 days after the date of the qualifying event, or, if the plan provides that COBRA coverage starts on the date of loss of coverage, the date the qualified beneficiary loses coverage under the plan. The Department has revised the final regulation, as suggested by one commenter, to make clear that the 44-day rule applies only in those cases where the employer is required to provide notice of a qualifying event to the plan administrator. Paragraph (b)(2) has also been revised to reflect the possibility that a plan may adopt a different starting date for COBRA coverage for different types of qualifying events.

Paragraph (b)(3) of the final regulation contains a special timing rule for multiemployer plans. No comments were received on this provision. Accordingly, paragraph (b)(3) is adopted without modification.

Paragraph (b)(4) of the final regulation sets forth the content requirements for the election notice. The Department received several comments on this section and the corresponding model election notice.

Several commenters argued that the regulation required too much information to be included in the election notice. In this regard, commenters suggested elimination of HIPAA information, information about alternative coverage and conversion rights, and plan contact information because much of that information is available in the SPD. Conversely, other commenters argued that the election notice did not include enough information and suggested that the content requirements be expanded in various ways.

Following a careful review of these comments, the Department has decided to retain the requirements that HIPAA information and plan contact information be included in the election notice. The Department believes it is important that qualified beneficiaries understand that election or non-election of COBRA continuation coverage may have significant implications for their future exercise of HIPAA rights and their ability to obtain health care coverage. The Department is concerned that the significance of the HIPAA information may be lost if the election notice merely refers to the SPD for more information about plan rights. Similarly, the Department believes that qualified beneficiaries should have ready access to additional information about COBRA and their rights under the plan. Because all qualified beneficiaries may not have the plan's SPD, requiring that specific contact information be included in the election notice is the best way to ensure that all qualified beneficiaries have access to the available information.

The Department is persuaded, however, that qualified beneficiaries would not be adversely affected by elimination of the requirement that information concerning alternative coverage and conversion rights be included in the election notice. Accordingly, the final regulation does not include those items in the list of required content for the election notice. In making these changes, the Department notes that information on these subjects is likely to be provided by the plan in some other form, either in connection with offering the individual a choice between COBRA coverage and the plan's alternative coverage options, or at the time that COBRA continuation coverage ends.[15]

Some commenters requested that the regulation and model election notice be modified to clarify that the election notice need not identify by name each qualified beneficiary entitled to elect continuation coverage. In response to this comment, paragraph (b)(4)(iii) has been revised to make clear that identification of qualified beneficiaries may be accomplished either by reference to their status (*e.g.*, employee, spouse, dependent child covered under the plan prior to the qualifying event) or by name. The Department intends that identification by status must be sufficiently detailed to permit the affected individuals to determine whether they are qualified beneficiaries. The model election notice has been revised accordingly.

As proposed, the model election notice included an optional paragraph describing the 65% health coverage tax credit (HCTC) created by the Trade Act of 2002 (the Trade Act) that may be used if an administrator believes employees might be eligible for trade adjustment assistance (TAA) and therefore eligible for the HCTC.[16] Some commenters suggested that Trade Act model language be expanded to refer not only to individuals potentially eligible for the HCTC because of eligibility for TAA (TAA-eligibles) but also to individuals potentially eligible for the HCTC because they may be receiving payments from the Pension Benefit Guaranty Corporation (PBGC-eligibles). Other commenters requested that the Trade Act paragraph be expanded to include additional information on how the new second COBRA election period created by the Trade Act relates to preexisting condition exclusion periods under HIPAA and how to become certified for TAA. Other commenters requested that the Department make clear that the election notice is not required to contain any Trade Act information.

As with the proposed regulation, the final regulation does not impose any specific disclosure requirement regarding rights and duties that may arise as a result of the Trade Act. Nonetheless, the Department has included an optional Trade Act paragraph in the model election notice to assist administrators who wish to notify potentially eligible individuals of their rights under the Trade Act as they relate to continuation coverage. In this regard, the Department has modified the model election notice Trade Act language to reference both PBGC-eligibles and TAA-eligibles. With regard to including more detailed information about Trade Act, the Department believes that the governmental sources identified in the model election notice represent the best sources for detailed information on Trade Act-related rights and procedures.

In addition to the aforementioned comments, the Department received a number of comments suggesting modifications to the model election notice to improve its clarity and readability. In finalizing the model election notice, the Department has taken into account all of these

health plan, are not governed by ERISA's claims procedure regulation unless they relate to a specific claim for benefits. *See* preamble to § 2560.503–1, 65 FR 70246, 70255 (Nov. 21, 2000).

[15] The COBRA provisions separately require plans to provide qualified beneficiaries who receive the maximum amount of COBRA coverage available to them the option of enrollment under a conversion health plan if such right is otherwise generally available under the plan. The option must be provided during the 180-day period ending on the expiration date of the period of COBRA coverage. *See* ERISA section 602(5).

[16] As noted in the preamble to the proposed regulation, it is the view of the Department that information on the possible availability of a new second COBRA election period in the event of TAA eligibility should, pursuant to § 2520.102–3(o), be included in the summary plan description of a group health plan as part of the discussion of the continuation coverage provisions of the plan. *See* 68 FR 31831, 31833 (May 28, 2003).

suggestions and has made a variety of revisions intended to improve, clarify, and simplify the model notice.

The Department received a number of comments on the notice requirements set forth in paragraphs (c) and (d) of proposed § 2590.606–4. Under paragraph (c) of the proposed § 2590.606–4, if a plan administrator receives a notice of a qualifying event pursuant to § 2590.606–3 from an individual not eligible to receive continuation coverage under the plan, the administrator would be required to provide notice to the individual(s) explaining why he or she is not entitled to such coverage. This unavailability notice was to be provided within the same time frame for providing an election notice, *i.e.*, within 14 days after receipt of the notice of a qualifying event. Under paragraph (d) of the proposal, the administrator would be required to provide notice to qualified beneficiaries in the event that continuation coverage terminates before the end of its maximum duration. This early termination notice was to be provided as soon as practicable following the administrator's determination that continuation coverage shall terminate.

A number of commenters argued that the notice provisions of paragraphs (c) and (d) should be eliminated entirely. These commenters generally argued that these notices are not required by statute, that the notices create serious administrative concerns, that they duplicate information already required to be disclosed in plan SPDs or election notices, and that they increase the risk of civil penalties and litigation for plan sponsors. At the same time, commenters indicated that many plans already provide similar notifications. A number of commenters supported these notice requirements, but suggested changes or clarifications.

With regard to the unavailability notice of paragraph (c), some commenters suggested that administrators should be required to provide the notice ''as soon as possible,'' although not later than 14 days after receiving the notice of qualifying event. Another commenter argued that the time frame for furnishing the unavailability notice should conform to the time frame for furnishing notice of a benefit claim denial. Other commenters requested clarification concerning the circumstances that would trigger the notice requirement.

After consideration of the comments, the Department has decided to retain the requirement that notice of unavailability of continuation coverage be provided, with some modification. It is the view of the Department that when a participant or beneficiary submits a request to the plan administrator for COBRA continuation coverage, the individual has an expectation of coverage unless (or until) he or she is notified to the contrary. The Department continues to believe that furnishing the unavailability notice in such circumstances will avoid misunderstandings in this area. The Department also believes that the proposed time frame of 14 days, paralleling the time frame for providing an election notice after receiving a notice of qualifying event, is appropriate for the unavailability notice. Therefore, the final regulation retains the time frame of the proposal.

Commenters questioned whether the unavailability notice is required only after receipt of ''a notice of a qualifying event furnished in accordance with § 2590.606–3,'' as stated in the proposal, or whether the unavailability notice must also be provided after receipt of any qualified beneficiary's notice furnished in accordance with § 2590.606–3. There appears to be little basis for distinguishing among the various qualified beneficiary notices that may be required to be furnished in accordance with § 2590.606–3 on the basis of the expectations of the individual furnishing the notice. Accordingly, the Department has modified the language of paragraph (c)(1) to clarify that the unavailability notice must be furnished when the plan administrator denies coverage after receiving a notice described in § 2590.606–3, regardless of the basis of the denial and regardless of whether the notice involves a first qualifying event, a second qualifying event, or a request for a disability extension. For example, the unavailability notice would be required to be provided when a plan administrator denies continuation coverage because it has been determined that no qualifying event had occurred or because the qualified beneficiary did not furnish the notice of qualifying event notice in a timely manner or did not provide complete information.

With respect to the early termination notice of paragraph (d) of the proposal, in addition to those commenters opposing the notice obligation in its entirety, some commenters suggested changes. One commenter suggested that plan administrators be required to provide an early termination notice in advance of terminating COBRA coverage and that plan administrators should not be allowed to combine the early termination notice with the notice of creditable coverage required to be provided under HIPAA. Another commenter objected to the proposal's adoption of the requirement that the early termination notice be furnished ''as soon as practicable,'' suggesting that a specific time frame would be more workable. One commenter suggested that the early termination notice be required only when coverage terminates ''voluntarily'' or for lack of premium payment.

Following consideration of the comments on paragraph (d), the Department has decided to retain the early termination notice requirements as proposed. As noted in the proposal, continuation coverage may be terminated earlier than the end of the maximum period for many different reasons. The Department continues to believe that providing a notice of early termination serves an important administrative function and permits qualified beneficiaries to take appropriate next steps to protect their access to health coverage, either on a group or individual basis.

In retaining the notice of early termination of continuation coverage requirement, the Department is not requiring that the notice be furnished before COBRA coverage can be terminated or within a specified time frame. To require notification to be made in advance of an otherwise permissible early termination of continuation coverage would extend COBRA continuation coverage beyond the statutory periods, which would be beyond the Department's interpretive and regulatory authority. In recognition of the fact that there may be instances when an administrator is able to furnish an early termination notice in advance of the early termination of COBRA coverage, the Department has retained the requirement that notice of an early termination be furnished as soon as reasonably practicable. The Department believes that this standard is in the best interest of the qualified beneficiaries.

The Department further believes that allowing plans to combine furnishing the early termination notice with the certificate of creditable coverage required under HIPAA would benefit the qualified beneficiary by providing related benefit information in a single information package and would benefit the plan as a result of reduced administrative costs. For this reason, the Department reiterates the view expressed in the proposal that nothing in these regulations is intended to prevent a plan administrator from combining the furnishing of an early termination notice with the furnishing of the certificate of creditable coverage.

One commenter recommended that the Department develop model notices for the unavailability notice and the early termination notice required under paragraphs (c) and (d) of § 2590.606–4. The Department has not adopted this suggestion due to the event-specific nature of the required notices. In the Department's view, it would be difficult to develop a single model form for such notices that would serve adequately to cover every circumstance, or even the most frequent circumstances, under which COBRA continuation coverage might be denied or terminated before the end of its maximum period.

C. Standards for Furnishing Notices

As discussed above, the final regulations provide standards for a variety of notices required to be furnished by and to qualified beneficiaries, employers, and plan administrators. Several commenters requested further guidance on the acceptable methods for furnishing the various notices addressed by the regulations. They also requested guidance on how to determine, for purposes of the various time limits, when a notice should be considered to be furnished.

The Department generally recognizes that disclosures may be furnished through a number of different methods. *See* § 2520.104b–1(b) (describing generally appropriate methods for furnishing reports, statements, notices, and other documents required under title I to individuals). With regard to general notices, election notices, unavailability notices, and early termination notices, each of which is required to be furnished by the plan administrator, the final regulations expressly provide that such notices must be furnished in a manner consistent with the standards set out in § 2520.104b–1(b). *See* § 2590.606–1(f); § 2590.606–4(f).

Under the standards set by § 2520.104b–1(b), and therefore under these regulations, a required notice generally should be considered ''furnished'' by a plan administrator as of the date of mailing, if mailed by first class mail, certified mail, or Express Mail; or as of the date of electronic transmission, if transmitted electronically.[17] When hand delivery is the chosen method of delivery, however, a notice would not be considered furnished until actually received by the individual to whom the notice is directed.[18] In the absence of written plan procedures to the contrary that are communicated to participants and beneficiaries, it is the view of the Department that the same standards would apply to notices of qualifying event furnished by an employer to the plan administrator and to COBRA notices provided by covered employees, qualified beneficiaries, and other persons acting on their behalf to plan administrators.

The regulations contain one exception to this general rule. Section 2590.606–4(b) expressly provides that the 14-day time limit applicable to plan administrators for furnishing an election notice will not begin to run until a plan administrator actually receives a notice furnished in accordance with the requirements of § 2590.606–2 or § 2590.606–3.

D. Effective and Applicability Dates

The Department received a number of comments expressing concern about the proposal's statement of the Department's intention to make final regulations effective and applicable as of the first day of the first plan year occurring on or after January 1, 2004. Commenters argued that such a short time period between publication and effective dates would not provide group health plans sufficient time for an orderly implementation of the changes necessary to accommodate the final COBRA continuation coverage notice regulations. The Department recognizes the importance of providing plans with an adequate period for making the changes to their COBRA processes required by these final COBRA notice regulations. It is in the public interest to enable plans to come into compliance smoothly and economically and to take advantage of the additional opportunities for administrative efficiency provided by these regulations. Accordingly, the Department has determined to provide a period of at least six months after publication of these final regulations before they will be applicable to notice obligations arising under group health plans.

In order to avoid confusion concerning the applicability date of the final rules, each rule (§§ 2590.606–1 through 2590.606–4) has been modified to add a new ''applicability'' paragraph. This paragraph provides that the regulation applies to notice obligations that arise on or after the first day of the first plan year beginning on or after the date that is six months after the date of publication of the final rules in the **Federal Register**.[19] The regulations are scheduled to become effective sixty days after the date of publication in the **Federal Register**.

The preamble to the proposed regulations made clear that plans could no longer rely upon prior guidance issued by the Department shortly after the enactment of COBRA, which provided a model general notice to be used in connection with plans' first becoming covered by COBRA.[20] The Department also stated in the proposal that, in the absence of final regulations, the Department would judge plan compliance with the COBRA statutory notice requirements under the standard set by the COBRA conference report: ''[E]mployers are required to operate in good faith compliance with a reasonable interpretation of these substantive rules, notice requirements, etc.''[21] Several commenters have requested guidance from the Department on whether, in the interim between issuance of the proposed regulations and a future applicability date for new final rules, they could rely on the proposed regulations as a reasonable interpretation of the COBRA statutory notice requirements that would be viewed by the Department as good faith compliance. The Department has determined that it is in the public interest to encourage early compliance with these new standards and, therefore, will, pending the applicability of the final rules, view compliance with either the proposed rules or the final rules, including use of the model notices as proposed or as finalized, to constitute good faith compliance with the COBRA statutory notice requirements.

E. Regulatory Impact Analysis

Summary

The regulatory standards promulgated in these regulations will benefit both

[17] *See* § 2520.104b–1(c) (disclosure through electronic media). The Department recognizes that other methods of furnishing may be available that, under the actual facts and circumstances, should be accorded the same deference as electronic transmission and first class mail.

[18] The use of interoffice mail for purposes of providing a notice to an employee should be considered tantamount to hand delivery and governed by the same standards.

[19] In response to public concerns about the proposed effective date, the Department issued a press release expressing its intention to give group health plans six months after the adoption of final rules to implement administrative changes required by the new rules. *Press Release*, EBSA, *Labor Department Announces Proposed Effective Date of COBRA Regulations Will Be Delayed* (September 17, 2003).

[20] The preamble to the proposed COBRA notice regulations explained that the early guidance and model general notice contained in Technical Release 86–2, issued June 26, 1986, no longer adequately reflected the COBRA provisions due to subsequent amendments and that use of that model notice would no longer be considered good faith compliance with the requirements of section 606(a)(1) of the Act. *See* 68 FR 31832, 31834 n.13 (May 28, 2003).

[21] H.R. Conf. Rep. No. 99–453 at 563.

plan sponsors and participants. They will dispel plan administrators' uncertainty about how to comply with COBRA notice provisions and reduce the risk of inadvertent violations. They will help participants and beneficiaries understand how to exercise their COBRA rights, thereby averting costly disputes and lost opportunities to elect COBRA coverage. This will result in an increase in the number of COBRA elections by qualified beneficiaries. These benefits of the regulations are expected to outweigh their costs.

New administrative costs imposed by these regulations are limited because plan sponsors and administrators already distribute notices pursuant to the COBRA statute, and many of their existing practices likely already satisfy the requirements of these regulations. The Department estimates the new administrative costs to be $2.6 million in the first year that the regulations are effective and $0.9 million annually in subsequent years. The $0.9 million ongoing annual cost is attributable to the new requirements to notify qualified beneficiaries when continuation coverage is unavailable or has been terminated before the maximum period of coverage has ended. The remaining $1.7 million first-year cost reflects the cost to plans to review existing notices and procedures, to make any necessary revisions, and to modify or develop newly required notices.

The Department also expects the number of COBRA elections to increase slightly, by between 0.5 percent and 1.0 percent, which will increase costs to employers. Employers can charge COBRA enrollees the cost of coverage plus an administrative charge, but those electing continuation coverage tend to have higher costs and therefore as a group enjoy a subsidy from plan sponsors equal to about one-third of the cost of their coverage. If COBRA elections increase, the amount of the subsidy will increase by a similar proportion, or between $12 million and $24 million annually.

Executive Order 12866

Under Executive Order 12866, the Department must determine whether the regulatory action is ''significant'' and therefore subject to the requirements of the Executive Order and subject to review by the Office of Management and Budget (OMB). Under section 3(f), the order defines a ''significant regulatory action'' as an action that is likely to result in a rule's (1) having an annual effect on the economy of $100 million or more, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

Pursuant to the terms of the Executive Order, it has been determined that this action is ''significant'' within the meaning of section 3(f)(4) of the Executive Order and therefore subject to review by the Office of Management and Budget (OMB).

Costs.—The administrative cost of these regulations is expected to be modest, primarily because COBRA's statutory provisions have been in effect since 1986. As a result, most group health plans, plan administrators, and health insurance issuers already have developed forms and procedures for the administration of COBRA notices. The Department estimates that the regulations will increase administrative costs by $2.6 million in the first year and $0.9 million annually in subsequent years.

Commenters on the proposed regulations remarked in general terms on the importance of controlling costs in relation to the benefits achieved for qualified beneficiaries. One commenter indicated that revising automated systems that generate COBRA notices would be more costly than the Department had estimated in connection with the proposal because many COBRA administrators currently issue COBRA notices that narrowly target individual audiences, such as spouses or children. Although some COBRA administrators choose to include additional information in their notices for certain types of qualified beneficiaries, the Department continues to believe that few COBRA administrators will be required to make significant changes in order to comply with the basic requirements of these notice provisions. COBRA administrators have in place processes that are, in fact, flexible enough to provide notices that satisfy the need for a generic product suitable for use by multiple plans while remaining sufficiently adaptable to include detailed information unique to the plan or individual qualified beneficiary.

Economies of scale also tend to moderate COBRA administrative costs because the majority of notice obligations are met through the purchase of COBRA administrative services from a number of COBRA administrators that is small relative to the number of group health plans they serve. In addition, not all COBRA administrators or plans will be required to make substantial changes. In estimating the impact of the proposed regulations and model forms, the Department assumed that many COBRA administrators and plans currently use notices that, for the most part, are in compliance with the requirements of the regulations. Comments received did not support a revision of that assumption for the estimate of the economic impact of the final rule. In response to comments, however, the Department has made certain clarifications to the proposed regulations with respect to content and format of the notices and has clarified the model notices accordingly. These changes, discussed more fully earlier in the preamble, will expand opportunities for COBRA administrators to fulfill plans' COBRA notice obligations within the context of their current practices. The clarification of the scope of applicability of the unavailability notice in § 2590.606–4(c) has resulted in an increase in the estimated cost of the final regulations of $204,000.

The Department expects the number of COBRA elections to increase slightly as a result of the implementation of these final regulations. Consequently, a portion of the cost of health care coverage will transfer from those new COBRA enrollees to plan sponsors, thereby increasing the subsidy from employers to COBRA enrollees. The transfer of costs arises because surveys indicate that although qualified beneficiaries that elect COBRA coverage pay a cost consisting of the applicable premium amount for group coverage plus an administrative charge, the actual average cost of continuation coverage is somewhat higher than the combined amount paid by the qualified beneficiary. Payment by a plan sponsor of the difference in these costs constitutes a subsidy of a qualified beneficiary's continuation coverage. As such, the transfer represents a cost to plan sponsors and a benefit to COBRA enrollees.

In estimating the amount of the transfer, the Department observed that the number of inquiries the Department receives annually concerning COBRA, about 59,000, is equivalent to just more than 1 percent of the estimated 5 million annual COBRA qualifying events. It is likely that some but not all of these inquiries reflect notice

inadequacies that these regulations would correct. The Department also noted that approximately 19 percent of qualifying events result in elections, and that the average annualized subsidy from plan sponsors to COBRA enrollees amounts to about $2,500 per enrollee. If between 0.5 percent and 1.0 percent of qualifying events involve missed opportunities due to inadequate notice, and 19 percent of those events would have resulted in elections, then the regulations, by correcting notice deficiencies, would increase COBRA enrollees by between 4,750 and 9,500 each year, and the aggregate subsidy by between $12 million and $24 million. Expressed in unit costs, for every one percent increase in the number of qualified beneficiaries who elect continuation coverage due to improved notices and procedures, there is an estimated incremental increase in cost of $24 million to plan sponsors or an average of approximately $58 per plan.

Both the administrative cost and the transfer cost will be borne by the 411,000 group health plans, covering a total of about 111 million participants and their dependents, that are currently required to offer continuation coverage. Cost estimates recognize only the cost of changes to existing practices that are likely to be associated with these rules; they exclude the pre-regulation impact of the statute itself. Estimates are grounded in an assumption as to the entity expected to perform the needed work (*e.g.*, a health insurer or professional administrator); the assumption should not be interpreted to bear on any party's legal responsibility for COBRA compliance. The costs of the regulations are equal to only one one-hundredth of 1 percent or less of total group health plan costs to entities subject to COBRA. Because the magnitude of the overall increase in costs to plans is small, the Department believes that it will not have a consequential effect on the availability of health coverage for employees.

Benefits.—The benefits of these rules arise from improved administrative efficiency, reduced exposure to risk, and from the potential avoidance of some unnecessary losses of group health plan coverage by qualified beneficiaries.

Improvements in the consistency and quality of information provided to participants and beneficiaries will help them understand their rights and limit their risk of losing the opportunity to elect COBRA coverage. Inconsistent procedures and notices that are not adequate as to content, timing, and form are known to generate questions, delays, disputes, and duplications of effort that require the expenditure of additional resources by both plan administrators and participants and beneficiaries to resolve. Although the magnitude of the costs and potential savings associated with administrative inefficiencies is unknown, clearer and more uniform standards should serve to avoid the otherwise unnecessary expense associated with rectifying procedural and substantive notice inadequacies. Providing greater certainty to plan sponsors and plan administrators as to how their notice obligations can be met should also limit risks to both plans and qualified beneficiaries. Plan sponsors and plan administrators who comply with this guidance will be less likely to be subjected to costly disputes, litigation, or penalties as a result of their compliance with this guidance.

The benefit to COBRA enrollees exceeds the financial value of the transfer insofar as the enrollees will gain access to high-value group coverage rather than having to choose between purchasing generally lower-value individual insurance, usually at a significantly higher rate than a group rate, or going without coverage altogether. Individual coverage is more costly and less efficient due in large part to significantly higher costs of individual policy administration. The uninsured are also known to seek preventive care less frequently and to delay or forgo treatment, which may lead to less favorable health outcomes and higher social costs for acute care at a later time. Interruptions in group health plan coverage can ultimately limit the portability of group coverage, as well. A reduction in the numbers of losses of coverage that result from notification failures results in efficiency gains to the extent that the qualified beneficiaries elect group health plan coverage rather than individual coverage.

Paperwork Reduction Act

In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520) (PRA 95), the Department submitted the information collection request (ICR) included in the Notice Requirements of the Health Care Continuation Coverage Provisions to the Office of Management and Budget (OMB) for review and clearance at the time the Notice of Proposed Rulemaking (NPRM) was published. In accordance with 5 CFR 1320.11(c) of the PRA, OMB issued a Notice of Action, on June 6, 2003, deferring action on the request for approval until the submission of the ICR in connection with the final rulemaking. Action was deferred in order to provide the Department with an opportunity to include changes resulting from comments on the proposed regulations. Accordingly, the Department has submitted the ICR included in the Notice of Final Regulations for review and clearance by OMB.

The Department has issued these rules to set minimum standards for the timing and content of the notices required under the continuation coverage provisions of part 6 of title I of ERISA, and to establish uniform standards for administering the notice process. In very general terms, the statute requires that qualified beneficiaries be offered the opportunity to elect to continue group health coverage after losses of coverage due to death of the covered employee, termination of employment or reduction of hours of employment, divorce or legal separation of the covered employee from the employee's spouse, loss of dependent child status, the covered employee's becoming entitled to Medicare, or bankruptcy of an employer that affects covered retirees and their families. Qualified beneficiaries may include covered employees, spouses of covered employees, and dependent children of covered employees. Coverage generally extends for up to 18 or 36 months, depending on the nature of the qualifying event.

The regulations set standards for six types of notices and provide two model notices in the following sections: General Notice of Continuation Coverage; Notice Requirements for Employers; Notice Requirements for Covered Employees and Qualified Beneficiaries; and Notice Requirements for Plan Administrators. The last section covers a notice of right to elect continuation coverage, a notice of unavailability of continuation coverage, and a notice of early termination of continuation coverage. Each of the regulations includes one or more ICRs. It should be noted that this Paperwork Reduction Act analysis includes the cost of the statute (the COBRA provisions) as well as the cost of the discretion exercised in this rulemaking. These costs were developed in the manner described below.

In order to develop estimates of the cost of the review, revision, development, and distribution of COBRA notices, it was first necessary to determine the numbers of participants and beneficiaries in plans that are required to offer COBRA coverage (generally, plans sponsored by employers with 20 or more employees), the numbers of beneficiaries who reside at addresses that are different from related covered employees, and the rates of occurrences of qualifying events that give rise to notice obligations. Also

required were estimates of the number of entities, such as group health insurance issuers and professional administrators, that would review COBRA notices; the number that would consequently revise COBRA notices; and the time required to do so for each type of notice.

The Department derived its estimates of 55.8 million covered employees, 55 million beneficiaries, and 2.5 million COBRA enrollees from the February and March 2001 Current Population Survey (CPS; Census Bureau household surveys), the 2000 Medical Expenditure Panel Survey, Household and Insurance Components (MEPS comprises surveys of households and private establishments conducted jointly by the Census Bureau and the Agency for Healthcare Research and Quality), and the 1996 Panel of the Survey of Income and Program Participation (SIPP; a Census Bureau longitudinal household survey). These data sources also indicate that 67,000 dependents live outside the household of related employees. Frequency rates for qualifying events were also developed from MEPS and SIPP.

An estimate of the number of plans covering these employees and dependents was also needed. About 50,000 group health plans currently file the Form 5500–Annual Return/Report of Employee Benefit Plan each year, including 38,000 large plans, and 8,000 small plans, and a number of plans that may not be required to file. For the purpose of regulatory analysis, plans with fewer than 100 participants are considered to be small. Because the majority of small group health plans are not required to file Form 5500, the number of such plans must be estimated from other data sources. CPS and MEPS data were used to derive an estimate of the number of employers that offer group health coverage, and to exclude employers within that group that have fewer than 20 employees. This estimate indicates that these regulations will affect about 411,000 plans, 38,000 of which are large, and 373,000 of which are small. The number of participants in large plans is estimated at 43.5 million. The number of participants in small plans is estimated to be 12.3 million.

The preparation and distribution of notices (discussed below) is accounted for as cost rather than hours because most COBRA administration is accomplished through the purchase of services for which fees are paid. Start-up costs that arise from these regulations pertain to the review and revision of existing forms and procedures and the development of the new early termination and unavailability notices. The costs for completing and distributing notices are ongoing operating costs.

The Department has assumed that all COBRA administrators will review their existing forms and procedures in response to promulgation of this guidance, and that some of those plan administrators will need to revise their notices and procedures. In order to derive an estimate of the number of entities that will review forms and procedures, the Department looked at the number of health insurers offering group products and the number of professional administrators providing services to group health plans. This results in an estimate of about 3,000 entities that perform COBRA administration for the majority of all plans. All of these entities are expected to review all of their notices and procedures in response to this regulatory guidance. The reviews are assumed to require 2 hours each for the general notice and the election notice. The reviews are expected to be conducted by professionals at the level of financial managers at a cost of $68 per hour.

In order to estimate the number of service providers that would be required to revise their existing notices, the Department first examined its data pertaining to the nature of the telephone inquiries it receives. These data show that about 59,000 inquiries pertaining to COBRA are received each year. Although the portion of these inquiries that pertain to notice provisions is unknown, as is the number of COBRA notification issues that do not give rise to contact with the Department, this number provides the only available proxy for a rate of notice-related difficulties. Given the roughly 5 million COBRA election notices provided each year, the rate of notice inadequacies is assumed to be about 1%. Because some COBRA inquiries received by the Department pertain to issues other than notices, the number of inadequate notices may range from .5% to 1% but 1% has been used for purposes of these estimates.

These regulations will require service providers to revise the .5% to 1% of notices that historically have been inadequate. The cost of these revisions will be driven in part by the number of service providers affected. The proportion of service providers affected may be larger than the proportion of notices that are inadequate. If inadequate notices are concentrated among smaller service providers, then the proportion of service providers affected will be more than .5% to 1%. The Department assumed that 3% of all service providers, or 90 providers, will be affected.

Modifications to the general notice and the election notice are assumed to require two hours per notice, at $68 per hour for a service provider. Additional start-up costs include the cost of four hours of professional time, at $68 per hour, to modify or develop the employer and employee notices and to develop the two newly required early termination and unavailability notices.

Ongoing operating costs arise from completing a notice upon the occurrence of each event that gives rise to a notice obligation and from distributing the completed notice. The Department did not attribute any ongoing operating cost to the provision of the general notice to covered employees and their spouses who reside with them. Under this final rule, a plan administrator may satisfy the general notice requirement by including the required content in the SPD and furnishing a single notice addressed to both the covered employee and the covered employee's spouse. The Department did, however, attribute an ongoing operating cost to completing and distributing the general notice to a spouse of a covered employee who resides at a separate address.

No burden is included for completing the employer's notice because it involves only information that the employer has at hand in its customary personnel practices. Similarly, no completion burden is calculated for the qualified beneficiaries' notices because this information is limited, readily available, and would be provided as a usual practice by only the qualified beneficiary who wishes to elect continuation coverage.

No cost has been included for the completion or distribution of the notice of unavailability of continuation coverage because there is currently no basis for determining the number of these notices that might be sent. The Department has assumed, however, that due to the clear and consistent information provided in the general notice, plan administrators will distribute only a limited number of unavailability notices annually and that the associated cost will be very small.

Finally, the cost for completing the election notice, at 4 minutes per notice, and the early termination notice, at 1 minute per notice, is estimated at $34 per hour. The 4 minutes required to complete an election notice represent a reduction from the 5 minutes originally calculated in the proposed regulation. The one minute saved as a result of clarifications in the final regulations regarding how plans may identify

qualified beneficiaries for purposes of the election notice, is expected to reduce the burden for completing election forms. As such, the estimated operating and maintenance costs for the ICR have been reduced by an estimated $2.7 million.

In determining the cost for distribution of COBRA notices, the Department noted in the proposed regulations that due to the nature of the rights and obligations involved in COBRA notice requirements most plan administrators tend not to choose electronic distribution methods for COBRA notices. The Department further noted that plans are not precluded from using electronic distribution methods that comply with regulations at 29 CFR.104b–1(b) and (c) and specifically requested comment on the use of electronic technologies in COBRA notice administration. The Department received one comment attesting to the availability of electronic information systems that are capable of transmitting COBRA notices and disclosures, and that are efficient, legally protective, and cost effective. The Department recognizes that there may be cost savings when information is transmitted electronically and that some plans may choose to use electronic technologies to fulfill their requirements. For purposes of the PRA, however, the Department has conservatively estimated costs based on first-class mail, which is currently the most common method for delivery of COBRA information. Postage and materials for distribution are estimated at $0.38 per notice. No assumption has been made as to the number of these notices that will be distributed electronically. The application of these assumptions results in an estimated annual distribution of 66,900 general notices, 2,809,000 employer notices, 651,000 qualified beneficiary notices, 4,699,000 plan administrator election notices, and 1,000,000 early termination notices. The number of unavailability notices is unknown.

Type of Review: New collection.

Agency: Employee Benefits Security Administration, Department of Labor.

Title: Notice Requirements of the Health Care Continuation Coverage Provisions.

OMB Number: 1210–0NEW.

Affected Public: Individuals or households; Business or other for-profit; Not-for-profit institutions.

Respondents: 411,000.

Frequency of Response: On occasion.

Responses: 9,225,900.

Estimated Total Burden Hours: None.

Total Annualized Capital/Startup Costs: 1,656,500.

Total Burden Cost (Operating and Maintenance): $14,723,400.

Total Annualized Cost: $16,379,900.

Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) and that are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a rule will not have a significant economic impact on a substantial number of small entities, section 604 of the RFA requires that the agency present a final regulatory flexibility analysis at the time of the publication of the NFRM describing the impact of the rule on small entities. Small entities include small businesses, organizations, and governmental jurisdictions.

For purposes of analysis under the RFA, EBSA proposes to continue to consider a small entity to be an employee benefit plan with fewer than 100 participants. The basis of this definition is found in section 104(a)(2) of the Act, which permits the Secretary to prescribe simplified annual reports for pension plans that cover fewer than 100 participants. Under section 104(a)(3), the Secretary may also provide for exemptions or simplified annual reporting and disclosure requirements for welfare benefit plans. Pursuant to the authority of section 104(a)(3), the Department has previously issued regulations at 29 CFR 2520.104–20, 2520.104–21, 2520.104–41, 2520.104–46, and 2520.104b–10, providing for simplified reporting requirements and limited exemptions from reporting and disclosure requirements for small plans, including unfunded or insured welfare plans covering fewer than 100 participants, that satisfy certain other requirements.

Further, while some large employers may have small plans, in general most small plans are maintained by small employers. Thus, EBSA believes that assessing the impact of this rule on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business based on size standards promulgated by the Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 *et seq.*). At the time of the publication of the NPRM, the Department requested comments on the appropriateness of the size standard used in evaluating the impact of this rule on small entities. No comments were received.

On the basis of this definition, EBSA estimates that the regulations will not have a significant impact on a substantial number of small entities. In support of this conclusion, the Department has conducted a final regulatory flexibility analysis, which is summarized below.

These regulations provide plans and qualified beneficiaries with greater certainty as to how the notice obligations of COBRA can be met. Inquiries to the Department, as well as public comment in response to the 1997 RFI, indicated that service providers and plan administrators would welcome guidance that would provide greater administrative efficiency and reduce exposure to risk resulting from procedural or substantive failures to meet notification requirements. Improvements in the quality of information provided to participants and beneficiaries is expected to help them understand their rights and limit their risk of losing the opportunity to elect the COBRA coverage that is required to be offered.

The COBRA provisions require a group health plan to offer qualified beneficiaries the opportunity to elect continuation coverage when they would otherwise lose group health coverage as a result of certain events described in the statute as ''qualifying events.'' Under section 608 of ERISA, the Secretary has the authority to carry out the provisions of part 6 of title I of ERISA. Further, the Conference Report that accompanied COBRA provided that the Secretary has the authority to issue regulations implementing the notice and disclosure provisions of part 6 of ERISA. The Department's objective in issuing the regulations is to provide guidelines that will assure plan administrators that they are in compliance with the notification provisions of COBRA and that participants and beneficiaries have sufficient information to exercise their COBRA rights. Small plans will benefit from clarifications about the content and timing of notices and from the likelihood that fewer determinations about COBRA coverage will be delayed, disputed, or appealed. In addition, an increased number of qualified beneficiaries in small health plans will be able to obtain COBRA continuation coverage.

The Department believes that, because of the expertise required, small plans will use COBRA administrators to review notices and to modify or adapt the Department's model notices for use

by the plan administrator. Generally, COBRA administrators offer plans ongoing administrative services, such as notifying employees about their group health plan continuation coverage, distributing and processing election forms, collecting and applying premium payments, and monitoring COBRA compliance. Small plans, in particular, are less likely to have in-house capabilities to handle these administrative tasks. For a service provider, reviewing and adopting or modifying forms for plans will result in some direct cost. COBRA administrators may choose to absorb some of the cost in order to maintain competitive products; others may charge the cost to their client plans. Where these costs are charged to plans, the cost will most likely be minimized because of the economies of scale inherent in the use of standardized forms and procedures. Costs to small plans are further reduced because of the large number of small plans that share the cost burden; there are approximately seven times as many small plans as large plans. Finally, to further reduce costs, the Department has provided two model notices that can be adapted by COBRA administrators for use by individual single-employer plans.

The Department estimates that there are approximately 2.5 million plans, each with fewer than 100 participants, that are considered small group health plans under the Department's definition. Among these, COBRA applies to only those plans with 20 or more employees, or 373,000 plans, with a total of approximately 12.3 million participants. While the majority of group health plans subject to COBRA are small plans, participation in those plans represents only about 22% of participation in all plans covered by COBRA.

The cost estimates for small plan compliance recognize only the cost of changes to existing practices associated with the regulations; they exclude the impact of the statute itself. Costs result from the likelihood that COBRA administrators may be required to modify two notices currently used by plans and may modify or develop other notices, including the two new early termination and unavailability notices. The cost to small group health plans to review and modify existing notices is estimated at $275,900. The cost to develop the two new notices and to complete and distribute the early termination notice is estimated at $299,400. No costs have been estimated for completion and distribution of the unavailability notice because the number of notices that might be sent cannot reasonably be determined; it is expected, however, that, with the additional clarity provided by the general notice regulation, the number of unavailability notices required to be sent will be small. The total cost to small plans for a service provider's assistance in reviewing, modifying, or developing notices is estimated to be $575,300, or $1.54 per small plan. The comparable average cost to large plans is $53.09 per plan.

Employers with small plans will also incur transfer costs as a result of an increase in the number of elections of continuation coverage by qualified beneficiaries who would have lost the opportunity to elect COBRA coverage absent improved notices and procedures. A portion of the cost of health care coverage previously borne by these individuals will be transferred to plan sponsors. However, because there are fewer participants in small plans, the per-plan transfer costs are considerably less than for large plans. The potential transfer cost to small plans is estimated to range between $2.6 million and $5.2 million, depending on the number of qualified beneficiaries who will elect COBRA coverage. The rate of potential losses of opportunity to elect COBRA coverage is estimated to fall between .5% and 1%. This represents an average of $7 to $14 per small plan. The comparable cost to large plans ranges from $9.4 million to $18.7 million, an average of $242 to $484 per plan. At the upper bound, the total estimated cost of the regulations for 373,000 small plans is $5.7 million, or an average of $15 per plan.

The basis for the regulations lies in the notice and disclosure provisions of part 6 of title I of ERISA. The regulations do not duplicate, overlap, or conflict with other Federal rules. The COBRA provisions have been in effect for many years. Accordingly, most plan administrators and COBRA administrators have developed procedures to comply with their statutory obligations. The regulations merely seek to provide additional, detailed guidance that will clarify a plan's administrative obligations and assure plan administrators and COBRA administrators that, in complying with the regulations, they have satisfied their statutory obligations.

The Department has attempted to minimize the burden of the review and potential revision of existing notices undertaken in response to this guidance by including model notices that can be adapted to plans' specific circumstances. This should lessen the use of resources for small and large plans alike.

Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), as well as Executive Order 12875, this rule does not include any federal mandate that may result in expenditures by state, local, or tribal governments in the aggregate of more than $100 million, or increased expenditures by the private sector of more than $100 million.

Small Business Regulatory Enforcement Fairness Act

The rule being issued here is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and has been transmitted to Congress and the Comptroller General for review. The rule is not a ''major rule,'' as that term is defined in 5 U.S.C. 804, because it is not likely to result in (1) an annual effect on the economy of $100 million or more; (2) a major increase in costs or prices for consumers, individual industries, or Federal, State, or local government agencies, or geographic regions; or (3) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Federalism Statement

Executive Order 13132 (Aug. 4, 1999) outlines fundamental principles of federalism and requires the adherence to specific criteria by Federal agencies in the process of their formulation and implementation of policies that have substantial direct effects on the States, the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. This rule does not have federalism implications because it has no substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Section 514 of ERISA provides, with certain exceptions specifically enumerated, that the provisions of titles I and IV of ERISA supersede any and all laws of the States as they relate to any employee benefit plan covered under ERISA. The requirements implemented in this rule do not alter the fundamental provisions of the statute with respect to employee benefit plans, and as such would have no implications for the States or the

relationship or distribution of power between the national government and the States.

List of Subjects in 29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Medical child support, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Department amends chapter XXV, subchapter L, part 2590 of title 29 of the Code of Federal Regulations as follows:

Subchapter L—Group Health Plans

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 1. The heading of subchapter L is revised to read as shown above.

■ 2. The heading of part 2590 is revised to read as shown above.

■ 3. The authority citation for part 2590 is revised to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 401(b), Pub. L. 105–200, 112 Stat. 645; and Secretary of Labor's Order No. 1–2003, 68 FR 5374 (Feb. 3, 2003).

Subpart A—[Amended]

■ 4. Part 290, Subpart A, is amended by adding §§ 2590.606–1 through 2590.606–4 to read as follows:

§ 2590.606–1. General notice of continuation coverage.

(a) *General.* Pursuant to section 606(a)(1) of the Employee Retirement Income Security Act of 1974, as amended (the Act), the administrator of a group health plan subject to the continuation coverage requirements of part 6 of title I of the Act shall provide, in accordance with this section, written notice to each covered employee and spouse of the covered employee (if any) of the right to continuation coverage provided under the plan.

(b) *Timing of notice.* (1) The notice required by paragraph (a) of this section shall be furnished to each employee and each employee's spouse, not later than the earlier of:

(i) The date that is 90 days after the date on which such individual's coverage under the plan commences, or, if later, the date that is 90 days after the date on which the plan first becomes subject to the continuation coverage requirements; or

(ii) The first date on which the administrator is required, pursuant to § 2590.606–4(b), to furnish the covered employee, spouse, or dependent child of such employee notice of a qualified beneficiary's right to elect continuation coverage.

(2) A notice that is furnished in accordance with paragraph (b)(1) of this section shall, for purposes of section 606(a)(1) of the Act, be deemed to be provided at the time of commencement of coverage under the plan.

(3) In any case in which an administrator is required to furnish a notice to a covered employee or spouse pursuant to paragraph (b)(1)(ii) of this section, the furnishing of a notice to such individual in accordance with § 2590.606–4(b) shall be deemed to satisfy the requirements of this section.

(c) *Content of notice.* The notice required by paragraph (a) of this section shall be written in a manner calculated to be understood by the average plan participant and shall contain the following information:

(1) The name of the plan under which continuation coverage is available, and the name, address and telephone number of a party or parties from whom additional information about the plan and continuation coverage can be obtained;

(2) A general description of the continuation coverage under the plan, including identification of the classes of individuals who may become qualified beneficiaries, the types of qualifying events that may give rise to the right to continuation coverage, the obligation of the employer to notify the plan administrator of the occurrence of certain qualifying events, the maximum period for which continuation coverage may be available, when and under what circumstances continuation coverage may be extended beyond the applicable maximum period, and the plan's requirements applicable to the payment of premiums for continuation coverage;

(3) An explanation of the plan's requirements regarding the responsibility of a qualified beneficiary to notify the administrator of a qualifying event that is a divorce, legal separation, or a child's ceasing to be a dependent under the terms of the plan, and a description of the plan's procedures for providing such notice;

(4) An explanation of the plan's requirements regarding the responsibility of qualified beneficiaries who are receiving continuation coverage to provide notice to the administrator of a determination by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 *et seq.* or 1381 *et seq.*), that a qualified beneficiary is disabled, and a description of the plan's procedures for providing such notice;

(5) An explanation of the importance of keeping the administrator informed of the current addresses of all participants or beneficiaries under the plan who are or may become qualified beneficiaries; and

(6) A statement that the notice does not fully describe continuation coverage or other rights under the plan and that more complete information regarding such rights is available from the plan administrator and in the plan's SPD.

(d) *Single notice rule.* A plan administrator may satisfy the requirement to provide notice in accordance with this section to a covered employee and the covered employee's spouse by furnishing a single notice addressed to both the covered employee and the covered employee's spouse, if, on the basis of the most recent information available to the plan, the covered employee's spouse resides at the same location as the covered employee, and the spouse's coverage under the plan commences on or after the date on which the covered employee's coverage commences, but not later than the date on which the notice required by this section is required to be provided to the covered employee. Nothing in this section shall be construed to create a requirement to provide a separate notice to dependent children who share a residence with a covered employer or a covered employee's spouse to whom notice is provided in accordance with this section.

(e) *Notice in summary plan description.* A plan administrator may satisfy the requirement to provide notice in accordance with this section by including the information described in paragraphs (c)(1), (2), (3), (4), and (5) of this section in a summary plan description meeting the requirements of § 2520.102–3 of this chapter furnished in accordance with paragraph (b) of this section.

(f) *Delivery of notice.* The notice required by this section shall be furnished in a manner consistent with the requirements of § 2520.104b–1 of this chapter, including paragraph (c) of that section relating to the use of electronic media.

(g) *Model notice.* The appendix to this section contains a model notice that is intended to assist administrators in discharging the notice obligations of this section. Use of the model notice is not mandatory. The model notice reflects the requirements of this section as they would apply to single-employer group health plans and must be modified if used to provide notice with respect to other types of group health plans, such as multiemployer plans or plans

established and maintained by employee organizations for their members. In order to use the model notice, administrators must appropriately add relevant information where indicated in the model notice, select among alternative language, and supplement the model notice to reflect applicable plan provisions. Items of information that are not applicable to a particular plan may be deleted. Use of the model notice, appropriately modified and supplemented, will be deemed to satisfy the notice content requirements of paragraph (c) of this section.

(h) *Applicability.* This section shall apply to any notice obligation described in this section that arises on or after the first day of the first plan year beginning on or after November 26, 2004.

BILLING CODE 4510–29–P

APPENDIX TO § 2590.606-1

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
(For use by single-employer group health plans)

** CONTINUATION COVERAGE RIGHTS UNDER COBRA**

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* are not required to pay] for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

[*If the Plan provides retiree health coverage, add the following paragraph:*]

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, [*add if Plan provides retiree health coverage:* commencement of a proceeding in bankruptcy with respect to the employer,] or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [*or enter longer period permitted under the terms of the Plan*] after the qualifying event occurs. You must provide this notice to: [*Enter name of appropriate party*]. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.*]

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice*].

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

[Enter name of group health plan and name (or position), address and phone number of party or parties from whom information about the plan and COBRA continuation coverage can be obtained on request.]

BILLING CODE 4910–29–C

§ 2590.606–2. Notice requirement for employers.

(a) *General.* Pursuant to section 606(a)(2) of the Employee Retirement Income Security Act of 1974, as amended (the Act), except as otherwise provided herein, the employer of a covered employee under a group health plan subject to the continuation coverage requirements of part 6 of title I of the Act shall provide, in accordance with this section, notice to the administrator of the plan of the occurrence of a qualifying event that is the covered employee's death, termination of employment (other than by reason of gross misconduct), reduction in hours of employment, Medicare entitlement, or a proceeding in a case under title 11, United States Code, with respect to the employer from whose employment the covered employee retired at any time.

(b) *Timing of notice.* The notice required by this section shall be furnished to the administrator of the plan—

(1) In the case of a plan that provides, with respect to a qualifying event, pursuant to section 607(5) of the Act, that continuation coverage and the applicable period for providing notice under section 606(a)(2) of the Act shall commence on the date of loss of coverage, not later than 30 days after the date on which a qualified beneficiary loses coverage under the plan due to the qualifying event;

(2) In the case of a multiemployer plan that provides, pursuant to section 606(a)(2) of the Act, for a longer period of time within which employers may provide notice of a qualifying event, not later than the end of the period provided pursuant to the plan's terms for such notice; and

(3) In all other cases, not later than 30 days after the date on which the qualifying event occurred.

(c) *Content of notice.* The notice required by this section shall include sufficient information to enable the administrator to determine the plan, the covered employee, the qualifying event, and the date of the qualifying event.

(d) *Multiemployer plan special rules.* This section shall not apply to any employer that maintains a multiemployer plan, with respect to qualifying events affecting coverage under such plan, if the plan provides, pursuant to section 606(b) of the Act, that the administrator shall determine whether such a qualifying event has occurred.

(e) *Applicability.* This section shall apply to any notice obligation described in this section that arises on or after the first day of the first plan year beginning on or after November 26, 2004.

§ 2590.606–3. Notice requirements for covered employees and qualified beneficiaries.

(a) *General.* In accordance with the authority of sections 505 and 606(a)(3) of the Employee Retirement Income Security Act of 1974, as amended (the Act), this section sets forth requirements for group health plans subject to the continuation coverage requirements of part 6 of title I of the Act with respect to the responsibility of covered employees and qualified beneficiaries to provide the following notices to administrators:

(1) Notice of the occurrence of a qualifying event that is a divorce or legal separation of a covered employee from his or her spouse;

(2) Notice of the occurrence of a qualifying event that is a beneficiary's ceasing to be covered under a plan as a dependent child of a participant;

(3) Notice of the occurrence of a second qualifying event after a qualified beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months;

(4) Notice that a qualified beneficiary entitled to receive continuation coverage with a maximum duration of 18 months has been determined by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 *et seq.* or 1381 *et seq.*) (SSA), to be disabled at any time during the first 60 days of continuation coverage; and

(5) Notice that a qualified beneficiary, with respect to whom a notice described in paragraph (a)(4) of this section has been provided, has subsequently been determined by the Social Security Administration, under title II or XVI of the SSA to no longer be disabled.

(b) *Reasonable procedures.* (1) A plan subject to the continuation coverage requirements shall establish reasonable procedures for the furnishing of the notices described in paragraph (a) of this section.

(2) For purposes of this section, a plan's notice procedures shall be deemed reasonable only if such procedures:

(i) Are described in the plan's summary plan description required by § 2520.102–3 of this chapter;

(ii) Specify the individual or entity designated to receive such notices;

(iii) Specify the means by which notice may be given;

(iv) Describe the information concerning the qualifying event or determination of disability that the plan deems necessary in order to provide continuation coverage rights consistent with the requirements of the Act; and

(v) Comply with the requirements of paragraphs (c), (d), and (e) of this section.

(3) A plan's procedures will not fail to be reasonable, pursuant to this section, solely because the procedures require a covered employee or qualified beneficiary to utilize a specific form to provide notice to the administrator, provided that any such form is easily available, without cost, to covered employees and qualified beneficiaries.

(4) If a plan has not established reasonable procedures for providing a notice required by this section, such notice shall be deemed to have been provided when a written or oral communication identifying a specific

event is made in a manner reasonably calculated to bring the information to the attention of any of the following:

(i) In the case of a single-employer plan, the person or organizational unit that customarily handles employee benefits matters of the employer;

(ii) In the case of a plan to which more than one unaffiliated employer contributes, or which is established or maintained by an employee organization, either the joint board, association, committee, or other similar group (or any member of any such group) administering the plan, or the person or organizational unit to which claims for benefits under the plan customarily are referred; or

(iii) In the case of a plan the benefits of which are provided or administered by an insurance company, insurance service, or other similar organization subject to regulation under the insurance laws of one or more States, the person or organizational unit that customarily handles claims for benefits under the plan or any officer of the insurance company, insurance service, or other similar organization.

(c) *Periods of time for providing notice.* A plan may establish a reasonable period of time for furnishing any of the notices described in paragraph (a) of this section, provided that any time limit imposed by the plan with respect to a particular notice may not be shorter than the time limit described in this paragraph (c) with respect to that notice.

(1) *Time limits for notices of qualifying events.* The period of time for furnishing a notice described in paragraph (a)(1), (2), or (3) of this section may not end before the date that is 60 days after the latest of:

(i) The date on which the relevant qualifying event occurs;

(ii) The date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or

(iii) The date on which the qualified beneficiary is informed, through the furnishing of the plan's summary plan description or the notice described in § 2590.606–1, of both the responsibility to provide the notice and the plan's procedures for providing such notice to the administrator.

(2) *Time limits for notice of disability determination.* (i) Subject to paragraph (c)(2)(ii) of this section, the period of time for furnishing the notice described in paragraph (a)(4) of this section may not end before the date that is 60 days after the latest of:

(A) The date of the disability determination by the Social Security Administration;

(B) The date on which a qualifying event occurs;

(C) The date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or

(D) The date on which the qualified beneficiary is informed, through the furnishing of the summary plan description or the notice described in § 2590.606–1, of both the responsibility to provide the notice and the plan's procedures for providing such notice to the administrator.

(ii) Notwithstanding paragraph (c)(2)(i) of this section, a plan may require the notice described in paragraph (a)(4) of this section to be furnished before the end of the first 18 months of continuation coverage.

(3) *Time limits for notice of change in disability status.* The period of time for furnishing the notice described in paragraph (a)(5) of this section may not end before the date that is 30 days after the later of:

(i) The date of the final determination by the Social Security Administration, under title II or XVI of the SSA, that the qualified beneficiary is no longer disabled; or

(ii) The date on which the qualified beneficiary is informed, through the furnishing of the plan's summary plan description or the notice described in § 2590.606–1, of both the responsibility to provide the notice and the plan's procedures for providing such notice to the administrator.

(d) *Required contents of notice.* (1) A plan may establish reasonable requirements for the content of any notice described in this section, provided that a plan may not deem a notice to have been provided untimely if such notice, although not containing all of the information required by the plan, is provided within the time limit established under the plan in conformity with paragraph (c) of this section, and the administrator is able to determine from such notice the plan, the covered employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event (if any) occurred.

(2) An administrator may require a notice that does not contain all of the information required by the plan to be supplemented with the additional information necessary to meet the plan's reasonable content requirements for such notice in order for the notice to be deemed to have been provided in accordance with this section.

(e) *Who may provide notice.* With respect to each of the notice requirements of this section, any individual who is either the covered employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered employee or qualified beneficiary may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the qualifying event.

(f) *Plan provisions.* To the extent that a plan provides a covered employee or qualified beneficiary a period of time longer than that specified in this section to provide notice to the administrator, the terms of the plan shall govern the time frame for such notice.

(g) *Additional rights to continuation coverage.* Nothing in this section shall be construed to preclude a plan from providing, in accordance with its terms, continuation coverage to a qualified beneficiary although a notice requirement of this section was not satisfied.

(h) *Applicability.* This section shall apply to any notice obligation described in this section that arises on or after the first day of the first plan year beginning on or after November 26, 2004.

§ 2590.606–4. Notice requirements for plan administrators.

(a) *General.* Pursuant to section 606(a)(4) of the Employee Retirement Income Security Act of 1974, as amended (the Act), the administrator of a group health plan subject to the continuation coverage requirements of Part 6 of title I of the Act shall provide, in accordance with this section, notice to each qualified beneficiary of the qualified beneficiary's rights to continuation coverage under the plan.

(b) *Notice of right to elect continuation coverage.* (1) Except as provided in paragraph (b) (2) or (3) of this section, upon receipt of a notice of qualifying event furnished in accordance with § 2590.606–2 or § 2590.606–3, the administrator shall furnish to each qualified beneficiary, not later than 14 days after receipt of the notice of qualifying event, a notice meeting the requirements of paragraph (b)(4) of this section.

(2) In the case of a plan with respect to which an employer of a covered employee is also the administrator of the plan, except as provided in paragraph (b)(3) of this section, if the employer is otherwise required to furnish a notice of a qualifying event to an administrator pursuant to § 2590.606–2, the administrator shall furnish to each qualified beneficiary a notice meeting the requirements of

paragraph (b)(4) of this section not later than 44 days after:

(i) In the case of a plan that provides, with respect to the qualifying event, that continuation coverage and the applicable period for providing notice under section 606(a)(2) of the Act shall commence with the date of loss of coverage, the date on which a qualified beneficiary loses coverage under the plan due to the qualifying event; or

(ii) In all other cases, the date on which the qualifying event occurred.

(3) In the case of a plan that is a multiemployer plan, a notice meeting the requirements of paragraph (b)(4) of this section shall be furnished not later than the later of:

(i) The end of the time period provided in paragraph (b)(1) of this section; or

(ii) The end of the time period provided in the terms of the plan for such purpose.

(4) The notice required by this paragraph (b) shall be written in a manner calculated to be understood by the average plan participant and shall contain the following information:

(i) The name of the plan under which continuation coverage is available; and the name, address and telephone number of the party responsible under the plan for the administration of continuation coverage benefits;

(ii) Identification of the qualifying event;

(iii) Identification, by status or name, of the qualified beneficiaries who are recognized by the plan as being entitled to elect continuation coverage with respect to the qualifying event, and the date on which coverage under the plan will terminate (or has terminated) unless continuation coverage is elected;

(iv) A statement that each individual who is a qualified beneficiary with respect to the qualifying event has an independent right to elect continuation coverage, that a covered employee or a qualified beneficiary who is the spouse of the covered employee (or was the spouse of the covered employee on the day before the qualifying event occurred) may elect continuation coverage on behalf of all other qualified beneficiaries with respect to the qualifying event, and that a parent or legal guardian may elect continuation coverage on behalf of a minor child;

(v) An explanation of the plan's procedures for electing continuation coverage, including an explanation of the time period during which the election must be made, and the date by which the election must be made;

(vi) An explanation of the consequences of failing to elect or waiving continuation coverage, including an explanation that a qualified beneficiary's decision whether to elect continuation coverage will affect the future rights of qualified beneficiaries to portability of group health coverage, guaranteed access to individual health coverage, and special enrollment under part 7 of title I of the Act, with a reference to where a qualified beneficiary may obtain additional information about such rights; and a description of the plan's procedures for revoking a waiver of the right to continuation coverage before the date by which the election must be made;

(vii) A description of the continuation coverage that will be made available under the plan, if elected, including the date on which such coverage will commence, either by providing a description of the coverage or by reference to the plan's summary plan description;

(viii) An explanation of the maximum period for which continuation coverage will be available under the plan, if elected; an explanation of the continuation coverage termination date; and an explanation of any events that might cause continuation coverage to be terminated earlier than the end of the maximum period;

(ix) A description of the circumstances (if any) under which the maximum period of continuation coverage may be extended due either to the occurrence of a second qualifying event or a determination by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 *et seq.* or 1381 *et seq.*) (SSA), that the qualified beneficiary is disabled, and the length of any such extension;

(x) In the case of a notice that offers continuation coverage with a maximum duration of less than 36 months, a description of the plan's requirements regarding the responsibility of qualified beneficiaries to provide notice of a second qualifying event and notice of a disability determination under the SSA, along with a description of the plan's procedures for providing such notices, including the times within which such notices must be provided and the consequences of failing to provide such notices. The notice shall also explain the responsibility of qualified beneficiaries to provide notice that a disabled qualified beneficiary has subsequently been determined to no longer be disabled;

(xi) A description of the amount, if any, that each qualified beneficiary will be required to pay for continuation coverage;

(xii) A description of the due dates for payments, the qualified beneficiaries' right to pay on a monthly basis, the grace periods for payment, the address to which payments should be sent, and the consequences of delayed payment and non-payment;

(xiii) An explanation of the importance of keeping the administrator informed of the current addresses of all participants or beneficiaries under the plan who are or may become qualified beneficiaries; and

(xiv) A statement that the notice does not fully describe continuation coverage or other rights under the plan, and that more complete information regarding such rights is available in the plan's summary plan description or from the plan administrator.

(c) *Notice of unavailability of continuation coverage.* (1) In the event that an administrator receives a notice furnished in accordance with § 2590.606–3 relating to a qualifying event, second qualifying event, or determination of disability by the Social Security Administration regarding a covered employee, qualified beneficiary, or other individual and determines that the individual is not entitled to continuation coverage under part 6 of title I of the Act, the administrator shall provide to such individual an explanation as to why the individual is not entitled to continuation coverage.

(2) The notice required by this paragraph (c) shall be written in a manner calculated to be understood by the average plan participant and shall be furnished by the administrator in accordance with the time frame set out in paragraph (b) of this section that would apply if the administrator received a notice of qualifying event and determined that the individual was entitled to continuation coverage.

(d) *Notice of termination of continuation coverage.* (1) The administrator of a plan that is providing continuation coverage to one or more qualified beneficiaries with respect to a qualifying event shall provide, in accordance with this paragraph (d), notice to each such qualified beneficiary of any termination of continuation coverage that takes effect earlier than the end of the maximum period of continuation coverage applicable to such qualifying event.

(2) The notice required by this paragraph (d) shall be written in a manner calculated to be understood by the average plan participant and shall contain the following information:

(i) The reason that continuation coverage has terminated earlier than the end of the maximum period of

continuation coverage applicable to such qualifying event;

(ii) The date of termination of continuation coverage; and

(iii) Any rights the qualified beneficiary may have under the plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right.

(3) The notice required by this paragraph (d) shall be furnished by the administrator as soon as practicable following the administrator's determination that continuation coverage shall terminate.

(e) *Special notice rules.* The notices required by paragraphs (b), (c), and (d) of this section shall be furnished to each qualified beneficiary or individual, except that:

(1) An administrator may provide notice to a covered employee and the covered employee's spouse by furnishing a single notice addressed to both the covered employee and the covered employee's spouse, if, on the basis of the most recent information available to the plan, the covered employee's spouse resides at the same location as the covered employee; and

(2) An administrator may provide notice to each qualified beneficiary who is the dependent child of a covered employee by furnishing a single notice to the covered employee or the covered employee's spouse, if, on the basis of the most recent information available to the plan, the dependent child resides at the same location as the individual to whom such notice is provided.

(f) *Delivery of notice.* The notices required by this section shall be furnished in any manner consistent with the requirements of § 2520.104b–1 of this chapter, including paragraph (c) of that section relating to the use of electronic media.

(g) *Model notice.* The appendix to this section contains a model notice that is intended to assist administrators in discharging the notice obligations of paragraph (b) of this section. Use of the model notice is not mandatory. The model notice reflects the requirements of this section as they would apply to single-employer group health plans and must be modified if used to provide notice with respect to other types of group health plans, such as multiemployer plans or plans established and maintained by employee organizations for their members. In order to use the model notice, administrators must appropriately add relevant information where indicated in the model notice, select among alternative language and supplement the model notice to reflect applicable plan provisions. Items of information that are not applicable to a particular plan may be deleted. Use of the model notice, appropriately modified and supplemented, will be deemed to satisfy the notice content requirements of paragraph (b)(4) of this section.

(h) *Applicability.* This section shall apply to any notice obligation described in this section that arises on or after the first day of the first plan year beginning on or after November 26, 2004.

BILLING CODE 4510–29–P

APPENDIX TO § 2590.606-4

MODEL COBRA CONTINUATION COVERAGE ELECTION NOTICE
(For use by single-employer group health plans)

[*Enter date of notice*]

Dear: [*Identify the qualified beneficiary(ies), by name or status*]

This notice contains important information about your right to continue your health care coverage in the [*enter name of group health plan*] (the Plan). Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to us.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on [*enter date*] due to [*check appropriate box*]:

☐ End of employment
☐ Death of employee
☐ Entitlement to Medicare
☐ Reduction in hours of employment
☐ Divorce or legal separation
☐ Loss of dependent child status

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to ___ months [*enter* 18 *or* 36*, as appropriate and check appropriate box or boxes; names may be added*]:

☐ Employee or former employee
☐ Spouse or former spouse
☐ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
☐ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, COBRA continuation coverage will begin on [*enter date*] and can last until [*enter date*]. [*Add, if appropriate:* You may elect any of the following options for COBRA continuation coverage: [*list available coverage options*].

COBRA continuation coverage will cost: [*enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.*] You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

COBRA CONTINUATION COVERAGE ELECTION FORM

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: [*Enter Name and Address*]

This Election Form must be completed and returned by mail [*or describe other means of submission and due date*]. If mailed, it must be post-marked no later than [*enter date*].

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA continuation coverage in the [*enter name of plan*] (the Plan) as indicated below:

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. _____

[*Add if appropriate:* Coverage option elected: _____]

b. _____

[*Add if appropriate:* Coverage option elected: _____]

c. _____

[*Add if appropriate:* Coverage option elected: _____]

_____ _____

Signature Date

_____ _____

Print Name Relationship to individual(s) listed above

_____

_____

_____ _____

Print Address Telephone number

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including [*add if applicable:* open enrollment and] special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a covered employee becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

[*If the maximum period shown on page 1 of this notice is less than 36 months, add the following three paragraphs:*]

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify [*enter name of party responsible for COBRA administration*] of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. [*Describe Plan provisions for requiring notice of disability determination, including time frames and procedures.*] Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

[*If employees might be eligible for trade adjustment assistance, the following information may be added*: The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact

[*enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan*] to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the [*enter due day for each monthly payment*] for that coverage period. [*If Plan offers other payment schedules, enter with appropriate dates:* You may instead make payments for continuation coverage for the following coverage periods, due on the following dates:]. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan [*select one:* will *or* will not] send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period [*or enter longer period permitted by Plan*] to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. [*If Plan suspends coverage during grace period for nonpayment, enter and modify as necessary:* However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.]

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

[*enter appropriate payment address*]

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Signed at Washington, DC., this 19th day of May, 2004.

Ann L. Combs,

Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

[FR Doc. 04–11796 Filed 5–25–04; 8:45 am]

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